Ute Indian Tribe Head Start

Child Physical Exam

Child's Name: _____Date of Birth: ____/____/____

Sex: Female ☐ Male ☐ Name of Parent or Guardian _____

Date of exam: ____/____/____ Physical Exam Administered by: _____

Required Screenings: Height: _____ Weight: _____ BMI: _____

☐ TB Test not required ☐Risk Factors present: TB test performed Date Read: ____/____/____
Results: _____

Exam	Normal	Abnormal	Comments
Blood Pressure			
Hearing R			
Hearing L			
Vision R			
Vision L			
Lead Level			
Hematocrit or			
Hemoglobin			
General Appearance			
Posture, Gait			
Speech			
Head			
Skin			
Eyes, External Aspects			
Optic Fundoscopic			
Ears External Canal			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Bones, Joint Muscles			
Neurological			
Glands			
Muscular Coordination			

Allergies: _____Medications: _____

☐ Well Child: No conditions identified of concern ☐ Conditions identified that are of concern

Comments: _____

_____

Physician Signature_____ Date: ____/____/____